

# CHAPTER 48

## Consent: Conditions of Admission/Placement

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### I. POLICY

The patient unit health record (UHR) shall reflect that every competent patient admitted to a General Acute Care Hospital, Correctional Treatment Center, Skilled Nursing Facility, Hospice, or placed in an Outpatient Housing Unit has been provided the opportunity to authorize routine basic care and treatment. Each patient shall be requested, on or about the time of admission or placement to sign the "Conditions of Admission/Placement" form. For patients unable to sign, the record shall reflect that additional attempts were made to obtain patient's consent for common and routine care.

The patient's signed "Conditions of Admission/Placement" form shall provide written evidence that the patient has agreed to the provision of general treatment and procedures, such as routine nursing care, blood test draws, x-rays, and other clinical services provided under the direction of a physician. Complex or invasive procedures shall require that the patient's informed consent be obtained by the clinician. Refer to policy: "Consent: Verification of Informed Consent or Refusal".

### II. PROCEDURE

A. Health care staff shall:

1. Provide the patient with a Conditions of Admission/Placement form. [CDC Form 7293]
2. After providing an opportunity for reading, have the patient sign the form, and include the full date (month, day, year) and time the form is signed.
3. Provide a competent adult to witness the signing of the form, and:
  - a. Enter the full date: month, day, year. This date shall be the date the patient signs the form.
  - b. Enter his/her title.
  - c. Provide a copy to the patient.
4. Incorporate the original signed and dated copy into the patient's inpatient or placement record.